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Testimony of
F.S. Gray, MD
In Support of
SB 54, An Act Concerning Uniform Preauthorization Standards for Health Care Providers and Health Insurers
Committee on Insurance and Real Estate
February 17, 2011

Good afternoon Senator Crisco, Representative Megna and Members of the Insurance and Real Estate committee, my name is Dr. Scott Gray and I am an orthopedic surgeon practicing in CT who continues to be held hostage by an unacceptable one sided contractual problem with the medical insurance contract process.

I am sorry that I am unable to personally attend this public hearing as I am out of town at the national meeting of the American Academy of Orthopaedic Surgeons, however I thank you for the opportunity to address support as I did last year for this most important bill. Last year I told you the story of one of my patients who had their total ankle surgery approved after an exhaustive pre certification process with his insurance company with conclusive provision to my office of a precertification number and the go ahead for the procedure. After the surgery was completed payment was denied on the basis of a claim of experimental surgery. I informed you that it took 9 months of huge appeal efforts to get payment and keep the patient from receiving a large bill, secure hospital payment and restore my ability to even provide this service to our patients again due to hospital skittishness.

Due to bill amendments that were unacceptable this effort had to be dropped. Since then I have had at least 3 more surgical procedures have payment denied. Two after proper pre certification and one denied after being informed that precertification was not required. In this last instance the procedure which has been performed for over ten years (a cartilage transplant procedure into my young patients ankle to restore her ability to walk without pain and attend college overseas and has long since had full peer reviewed level II acceptance by the F.S. Gray, MD

orthopaedic community continues to be denied upon appeal despite volumes of literature provided to the insurance company. Even the medical director, an internist who denied retroactively the payment agrees that the procedure should be paid for however the process that occurred he tells me is place to put the burden on me to appeal to get paid. The gaul here is that we physicians follow the industry rules, do what is required of us in order to get certification however there is no accountability on the insurance end regarding their own due diligence. I could stomach this fight before approval....although distasteful; however after performance of the procedure it leaves the physician baffled, causes huge overhead expense and time to rectify and leaves the patient wondering what on earth their premium is paying for when they were also sure that their procedure would be covered. This problem continues to be unacceptable. Although I am unable to personally attend this hearing I have made arrangements for the parents of one of these denials to tell their side of this story to provide you with the consumer frustration part as they must now receive a large bill from me and the surgical facility and the anesthesiologist for a service they expected to be covered based on what they know are the rules and process that were followed.

I thank you for your time and consideration and urge you to help the consumers in the state and the doctors that treat them to be treated fairly by forcing the insurance industry to adhere to common sense and fair payment rules once pre certification and preauthorization has occurred. I look forward to working with members of this Committee to develop bill language that will adequately address and correct the problem.